You Can Run, but You Can't Hide:
Long-Term Care for Older People and Younger Persons with Disabilities

Joshua M. Wiener, Ph.D.
Senior Fellow and Program Director
Aging, Disability and Long-Term Care
RTI International
701 13th Street, NW
Suite 750
Washington, DC 20005
(202) 728-2094
jwiener@rti.org

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The financing and organization of long-term care for older people and younger persons with disabilities needs reform. Although long-term disability is a normal life risk and nearly half of all older persons will spend some time in a nursing home, the need for long-term care comes as a surprise to most Americans and their families who have to cope with it (Spillman and Lubitz, 2002). With very little public or private insurance against the high costs of nursing home and home care available, users of long-term care incur very high out-of-pocket costs. As a result, Medicaid is the principal source of financing for long-term care, even though many of the users were not initially poor. Although most persons prefer home and community-based services, the vast bulk of long-term care expenditures are for institutional care. Finally, with the aging of the population, demand for long-term care will increase in the future, placing financial pressure on public programs and private resources.

Despite these problems and the fact that long-term care is the third leg of retirement security, public policymakers have not given it the attention it deserves. We have had substantial debates about how to assure income security (Social Security) and health care (Medicare), but not how to make sure that people receive high quality long-term care in a way that is affordable to them and to society.

In my testimony today, I would like to make six points:

- The financial burden of long-term care will increase as the population ages, but, by itself, it will be manageable.
- The U.S. faces serious labor force problems regarding how to recruit and retain high quality workers to provide this care.
- Private long-term care insurance can play more of a role, but older people cannot afford it.
- Long-term care insurance needs stronger regulation, particularly related to inflation protection.
- Home equity conversions can help, but most people with significant disabilities do not have much home equity.
- Long-term care is predominantly a public responsibility throughout the developed world and is likely to remain so.

The aging of the baby boom generation will increase demand for long-term care, but it will not be unaffordable by itself.

The need for long-term care services affects persons of all ages, but the prevalence of disability increases sharply with age. The Census Bureau projects that the population age 85 and older, the population most likely to need long-term care services, will increase from 4.3 million in 2000 to 20.9 million in 2050. About half of all persons

age 85 and older had a disability in the community or are in a nursing home (Johnson and Wiener, 2006). Although there appears to have been a decline in disability rates among the older population over the last 20 years (Freedman, Martin and Schoeni, 2002), the large increase in the number of older people due to the aging of the baby boom generation ensures that the demand for long-term care services will rise. Some analysts estimate that the obesity epidemic and the resulting diabetes will offset past declines in disability rates and that disability rates will increase again in the future (Lakdawalla, Battacharya and Goldman, 2004).

The likely increase in demand for long-term care has led some observers to forecast an apocalyptic situation where the financial burdens become so great that they are unbearable for our society. Although nobody knows the future, this doomsday scenario is unlikely. According to the Congressional Budget Office (2004), total (public and private) long-term care expenditures are older people are projected to increase from 1.3 percent of the Gross Domestic Product (GDP) in 2000 to 1.5 to 2.0 percent of GDP in 2040. These projections are in line with my own earlier projections (Wiener, Illston and Hanley, 1994), although they probably should be somewhat higher because of the workforce issues discussed below. Ultimately, we will have to pay long-term care workers more to induce them to provide services. Within a health care system that is already 18 percent of GDP, these changes are relatively modest. Moreover, many other countries, such as Sweden, Japan, Germany, and England, already have populations that are much older than ours without unduly dire results (Organization for Economic Co-operation and Development, 2005).

In sum, long-term care is sure to be a larger financial burden on public and private burden in the future. However, the increase, by itself, should not be so large as to immobilize public initiatives to make the system better. The question is more one of political will than economics. The issue is complicated, however, by the fact that long-term care mostly affects the same populations that uses Medicare and Social Security, both of which have substantial long-run financial problems.

The United States faces a serious problem recruiting and retaining high quality long-term care caregivers.

Although some technological improvements are possible, long-term care is fundamentally a hands-on service provided by people, not machines. The United States faces serious problems in recruiting and retaining long-term care workers, a situation that will only grow worse over time. Nationally, turnover rates for certified nurse assistants in nursing homes were estimated to be approximately 78 percent per year in 2001, which is likely to adversely affect quality of care (American Health Care Association, 2002). As a result of high turnover and vacancy rates, providers incur substantial recruitment and training costs (Leon, Marainen and Marcott, 2001; Pillemer, 1996). Major reasons for the shortages include low wages and benefits, a lack of career ladder, inadequate training and poor work culture.

Over the long run, there is a major demographic imbalance between the number of people likely to need long-term care services and the number of people likely to be available to provide it. The ratio of persons ages 20-64 (the working age population) to the number of persons age 85 and older (the population most likely to need long-term care services) is projected to decline from 37.8 in 2000 to 11.4 in 2050 (Lewin Group, 2002). While this data are often used to illustrate the potential economic burden of Medicare, Medicaid and Social Security, they also have profound implications for the availability of personnel to provide long-term care services. It will be far more difficult to recruit and retain workers in the future, and they probably will be more costly.

Private long-term care insurance can play more of a role, but most older people cannot afford it.

Over the last 20 years, a small but growing market for private long-term care insurance has developed. As of 2001, approximately 8 percent of older people and far less than one percent of the nonelderly population had some form of private long-term care insurance (Johnson and Uccello, 2005). Public policymakers have been interested in promoting private long-term care insurance as a way of increasing choices available to individuals and reducing Medicaid expenditures by middle-class beneficiaries.

A substantial body of research suggests that the affordability of private long-term care insurance is a major barrier to its purchase. Most studies found that only a relatively small minority of the elderly population (generally 10 to 20 percent) can afford good quality private long-term care insurance (see, for example, Wiener, Illston and Hanley, 1994; Rivlin and Wiener, 1988; Rubin, Wiener and Meiners, 1989; and Wiener and Rubin, 1989). Projections suggest that these percentages will increase, but that the bulk of older people will still not be able to afford policies in the future. Other research has found higher percentages of older people to be able to afford private long-term care insurance by assuming purchase of policies with more limited coverage, by assuming that older people would use assets as well as income to pay premiums, or by excluding a large proportion of older people from the pool of people considered interested in purchasing insurance.

That affordability is a problem should not be a surprise. According to a study by America's Health Insurance Plans, the average premium for a good quality policy with inflation protection purchased at age 65 was $2,346 in 2002; the average premium for a good quality policy with inflation protection and nonforfeiture benefits was $2,862 in 2002 (America's Health Insurance Plans, 2004). Thus, premiums for a married couple approximate $5,000 per year for a good policy. Premiums at age 79 are approximately three times as much. However, the median income for households headed by persons aged 65-74 was only $34,243 in 2004, and declines sharply with increasing age (U.S. Census Bureau, 2006). Thus, even with generous assumptions about the willingness of people to pay, private long-term care insurance is very expensive for most older people.

A number of policy strategies have been proposed to make long-term care insurance more affordable. One possible strategy is to encourage purchase at younger ages, when premiums are lower. Premiums for a good quality policy with inflation protection and nonforfeiture benefits purchased at age 50 are half what they are at age 65. While some employers do offer these policies, they rarely contribute towards the cost of the premiums. In addition, people in their 40s and 50s are concerned about their mortgage payments, child care costs, college education expenses for their children, and general retirement; they are rarely interested in long-term care. The marketing dilemma is that people are interested in long-term care when they are older and cannot afford the policies; at the age when they could afford the policies, they are not very interested.

Another possible strategy is to make long-term care insurance a tax deductible expense, a strategy which President Bush and the insurance industry have endorsed. This approach, especially for the elderly population, is likely to be ineffective because it would not substantially reduce the price of the insurance. According to the Urban Institute-Brookings Institute Tax Policy Center, the median effective federal individual income tax rate for elderly childless households was 1.5 percent in 2003; for the older population as a whole, it was only 7.3 percent. Thus, for the median elderly household, it would reduce the $2,862 premium cited above by $43. Since tax deductions benefit upper-income households more than lower- and moderate-income households, this strategy would also be regressive in terms of tax policy. An earlier analysis of proposed tax incentives (Wiener, Illston and Hanley, 1994) found that these policies were expensive in terms of lost revenue, but mostly benefited persons who would have purchased policies without the increased tax benefits.

Long-term care insurance requires tougher regulation, especially regarding inflation protection.

The quality of long-term care insurance policies has improved dramatically over the last 20 years and there are many good products currently available. Regulation by the states, encouraged by the tax provisions in the Health Insurance Portability and Accountability Act (HIPAA), deserves some of the credit for pushing policies to improve.

A major gap in existing regulation of private long-term care insurance concerns how inflation is addressed. It is critical to solve this issue because health care inflation, including long-term care, is substantial and policies are typically sold years in advance of when benefits are used. Most states only require that insurers offer a product where the indemnity value increases by 5 percent per year. Most policies in force today do not automatically adjust for inflation over time; instead they provide fixed dollar maximum benefits per day in a nursing home or visit by a home care provider.

Failure to have automatic inflation adjustments can have a devastating impact on the purchasing power of the policies. For example, at 5 percent annual inflation, a $100 per day benefit in a nursing home at age 65 would need to pay $265 per day at age 85 to maintain the same purchasing power. The longer the period of time between the initial purchase of the power and its use, the more important it is to have compound inflation protection. For example, a $100 per day indemnity benefit purchased at age 50 would need to pay $551 at age 85 to maintain the same purchasing power.

Insurance companies often offer the insured the option of purchasing additional coverage over time at the new attained age instead of automatic inflation adjustments. Since disability rates are exponential by age, premiums quickly become unaffordable. To retain purchasing power, the premiums at age 82 would be approximately ten times, in nominal dollars, what they were at age 62. The premiums will skyrocket over time, but the incomes of the elderly will not.

It is not hard to understand why insurers resist regulations requiring inflation adjusted policies—policies with inflation protection cost are roughly twice the price of policies without inflation adjustments. Higher premiums mean lower sales. Nonetheless, policies without inflation protection may not provide substantial protection against the costs of long-term care.

Tapping into home equity can help, but most people with disabilities do not have a lot of home equity.

Inspired in part by the recent increase in home prices, policymakers are increasingly interested in finding ways to use home equity conversions to finance long-term care. Typically, these mechanisms are home equity loans that do not have to be paid off until the borrower dies or moves from the house. While there is little doubt that home equity accounts for the vast majority of the wealth of the older population, policymakers need to be cautious in how much home equity can be used to pay for long-term care (Merlis, 2005). In 2002, median home equity among older persons with disabilities was $56,956 and $35,640 for persons with severe disabilities (Johnson and Wiener, 2006). Restrictions on the amount of home equity that can be used, closing costs for home equity conversions, including mortgage insurance, and interest costs substantially erode the amount of money available to pay for long-term care directly. Merlis (2005) estimated that for a 70-year old borrower, these costs could account for about a third of the cost of the loan over 15 years.

Some analysts have suggested using home equity conversions to purchase private long-term care insurance, which provides more coverage than may be available though direct use of home equity to purchase long-term care services. While the use of home equity would marginally increase the proportion of older people who can afford private long-term care insurance, it seems unreasonable to expect that people will partly deplete their major asset to purchase a product, one of whose major purposes is to protect their major asset. Moreover, individually sold private long-term care insurance has very high overhead, due to substantial marketing, commission, and profit costs. Most private long-term care insurance policies have long-term loss ratios of 60 percent, which roughly means that 60 percent of the premiums are used for benefits. Thus, the use of home equity (with a "loss ratio" of 66 percent) to purchase a private long-term care insurance policy (with a loss ratio of 60 percent) would result in only about one in three home equity dollars providing benefits, which is an inefficient use of funds.

Conclusion: While the private sector plays a role, long-term care is predominantly a public responsibility in the developed world.

The major focus of federal policymakers in long-term care financing over the last decade has been to find ways to increase the role of the private sector and to decrease the role of the public sector. Public sector financing currently dominates long-term care, accounting for about two thirds of long-term care expenditures for older people (U.S. Congressional Budget Office, 2004).[1] Moreover, approximately 78 percent of nursing home residents have their care financed by either Medicare or Medicaid (American Health Care Association, 2006). The United States is not alone in this large role played by the public sector. In Ireland, New Zealand, Japan, Australia, Canada, Germany, the United Kingdom, the Netherlands, Norway and Sweden, long-term care is financed primarily through public programs. Only in Germany does private long-term care insurance play a significant role, and that is as an alternative for upper-income individuals to the social insurance provided by the quasi-public "sickness funds."

While there is little doubt that private sector financing can play a bigger role than it plays now, it seems unlikely that private financing can become the dominant source of funding for long-term care without more radical and costly initiatives than are currently contemplated. Research suggests, for example, that the people who can afford private long-term care insurance are not the people who spend down to Medicaid (Rivlin and Wiener, 1988; Wiener, Illston and Hanley, 1994; and Rubin and Wiener, 1989). As a result, expansion of private long-term care insurance is unlikely to affect Medicaid costs more than marginally. Thus, federal policymakers bear a special responsibility to improve Medicare and Medicaid for the majority of the people who need and use long-term care services.

[1] If mandatory out-of-pocket contributions towards the cost of care by Medicaid beneficiaries in nursing homes were counted, the public role would be substantially higher.

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